



# **MMW COALITION**

***A collaborative project among the Health & Disability Advocates, Progress Center for Independent Living and Suburban Area Agency on Aging  
To Make Medicare Work for Illinois Consumers***

**Make Medicare Work Summit  
Monday, February 28, 2005  
8:30AM – 3:30PM**

## **Report to the White House Conference on Aging**

One Hundred twenty five individuals attended the first Make Medicare Work Summit on Monday, February 28, 2005 at the Holiday Inn Furniture Mart in Chicago. Twenty-five percent of those in attendance were over the age of 60.

The agenda was followed with: presentations explaining the purpose of the day; provision of a complete overview of the Medicare Modernization Act; discussion of who will be affected by low-income provisions of the law; what challenges exist in reaching and explaining the law; and what state and federal plans are being developed for the implementation of the Act.

The Make Medicare Work Coalition's Illinois Medicare Consumer Profile was released at the Summit – key findings include:

- More than 1.5 million Medicare consumers in Illinois will be faced with a choice to enroll in Medicare Part D by the fall of 2005.
- 150,000 “dual-eligibles” – individuals receiving both Medicaid and Medicare – will lose Medicaid prescription drug coverage on January 1, 2006. (They will begin receiving Medicare Part D benefits instead.) If education efforts are not sufficient, many of the dual eligibles could be automatically enrolled in a Medicare prescription drug plan that does not meet their needs.
- 170,000 Medicare consumers who are low-income who may be eligible for assistance to help pay for Medicare Part D – may be at risk to receive less assistance than they are currently receiving under state programs such as SeniorCare
- 77,000 Medicare consumers in long term care facilities will have to enroll in Medicare Part D and may have to change from their present long term care pharmacy to a new Medicare prescription drug plan.

The group broke into two concurrent discussion sessions, on policy issues and education/outreach/enrollment issues, around the implementation of the new Medicare prescription drug coverage. Recommendations for action from the break out sessions included a wide variety of activities:

- Advocacy at the state level is needed to assure that current pharmaceutical assistance programs are maintained for older and disabled persons. Reports from the Illinois Department of Public Aid and Department on Aging were that this goal is shared by the current state Administration.

- The Medicare Modernization Act should be modified to postpone the penalty period for delayed enrollment in the new PDPs. The current schedule will increase many individuals' costs for the remainder of their lives. The current provisions do not take into consideration how previous benefit programs have unfolded, with very slow enrollment of a majority of eligible persons.
- The federal government should develop a clear linkage from the Social Security Administration of low-income beneficiaries to the full array of benefits at the federal, state and local levels. This goal can be achieved through the BenefitsCheckUp.org program and a funded network of community agencies for older persons to be referred to (Illinois' Senior Health Assistance Program sites are one model for this. This is administered through the Older Americans Act programs).
- CMS targeted outreach should be tied to ABC Coalitions and other community-based efforts to coordinate services. The distribution of resources should foster collaboration, not competition among these resources.
- Health care literacy, and most specifically health coverage literacy, is low with most people still not understanding basic Medicare. General advertising and mass mailings help increase awareness, but most people will need individual help to make decisions. A significant amount of the support for publicity campaigns, over-reliance on web pages, and nationwide hot lines that have little knowledge about local and state programming should be re-directed to networks of community agencies providing outreach, education and individual assistance. The Red Tape Cutters model works in the Chicago area and should be expanded state wide and nationally.
- The cost of medications should be limited under Medicare and not left to corporate deals that provide higher prices for some prescriptions and lower for others based on stock investments and other interests between PDP and the pharmaceutical industry. National leverage may set such limitations.
- Research on new pharmaceuticals is government supported. The investment in such research should be identified in pricing of new pharmaceuticals.
- Marketing costs of pharmaceuticals have been exposed as excessive, with most companies reducing such expenses. Reduced expenses should reduce the cost of the medications for every consumer.
- The MMA should be amended to adopt a set of standard plans similar to the Medicare Supplemental system. The concept of 'actuarially equivalent' is totally wrong for the majority of older persons who are not prepared to make decisions on complex formulas and can not make clear judgments on which PDP to select. The professionals working with the MMW have no way of explaining up front loads or later loads that impact the predictability of the cost of care. There needs to be a simpler way to compare the plan benefits. Standard designs, as well as standard definitions of terms should be available.
- Appeals on medically necessary formularies should be granted first then evaluated. Life should be a primary value of the program.
- The new prescription drug coverage and low income subsidies should not place other federal support and benefit programs at risk of being reduced or ending for low-income older persons or people with disabilities.
- The MMA should be amended to require that Long-Term Care facilities have continuity in all medications required for current and future patients upon implementation of the program without interruption in pharmacy services. There is tremendous concern among advocates and service providers that the new

program will lead to confusion and disruptions in critical medications for the most vulnerable individuals.

- Resources to provide needed accommodations and specific tools should be made widely available in community agencies to be able to serve people with physical and cognitive impairments, low literacy and language barriers. The expense of these materials, tools and skills should be considered in planning and distributing resources.